

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02789

96

1. PLACE OF DEATH:

County.....*Cecil*
 City or town.....*Charlestown*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*Life*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Cecil*
 City or town.....*Charlestown*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edith P Barnes

3. (b) Social Security Number

4. Sex.....*Female*5. Color or race.....*white*6.(a) Single, married, widowed, or divorced.....*Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*Aug. 2, 1876*

6.(c) If alive, give age..... years

8. AGE:

Years.....*68*Months.....*7*Days.....*16*

If less than one day..... hrs. min.

9. Birthplace.....*Cecil Co. Charlestown, Md.*

(Town, county, and state)

10. Usual occupation.....*Care own home*

11. Industry or business.....

FATHER

12. Name.....*George W. Barnes*13. Birthplace.....*Sayford Co. Md.*14. Maiden name.....*Rachel Kirby*15. Birthplace.....*Sayford Co., Md.*16. Informant.....*Belle Barnes*Address.....*Charlestown, Md.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon.....*March 20, 1945*

(month) (day) (year)

Cemetery or crematory.....*Angel Hill*Location.....*Navaswe Grace, Md.*18. Funeral director.....*Lee A. Patterson & Son*Address.....*Perryville, Md.*19. Date rec'd by registrar.....*March 21, 1945*

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 18, 1945* at.....*5 a.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1st, 1944 to.....*March 18, 1945*and that I last saw him alive on.....*March 17, 1945*Immediate cause of death.....*Gangrene of**Lower Extremities*

DURATION

*6 mos*Due to.....*atherosclerosis**3 yrs*

Due to.....

Other conditions.....*Diabetes mellitus**8 yrs*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....*J. F. Magraw*

M. D. or other

Address.....*Perryville, Md.*Date signed.....*3/20/45*

CERTIFICATE OF DEATH

RECEIVED

APR 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

CERTIFICATE OF DEATH

02790

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Belton
(If outside city or town limits, write RURAL and give nearest town)How long to above place of death? 102 days

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? 102 days

3. (a) FULL NAME

Jethro J. Benjamin

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Amanda Benjamin

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 13 1877

8. AGE: Years Months Days If less than one day

67 7 6 hrs. min.9. Birthplace Leslie, Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Jethro J. Benjamin13. Birthplace Leslie, Md.14. Maiden name Elizabeth Abrance15. Birthplace Port Deposit Md16. Informant Mrs L. M. BenjaminAddress Port Deposit Md17. Burial Date thereof Mar 22, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bay View MdLocation 3rd & V. Ave. Md18. Funeral director Joseph P. LinnAddress North East Md19. Mar 21 19 45 Th. Trajan

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war was a Veteran

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 12:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him alive on March 19 19 45

Immediate cause of death _____ DURATION

Cerebrum of Degraded 12 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations non operative

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edw. Green Emmell

M. D. or other _____

Address North East, Md. Date signed Mar 21 1945

CERTIFICATE OF DEATH

RECEIVED

MAR 23 1945

BUREAU

CERTIFICATE OF DEATH

96

..... Date signed..... 3/21/91.....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

APR 5 1945

BUREAU V.C.

RECEIVED APR 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 338

02792

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit ST. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 hr.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Port Deposit General
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles Bryan Burlin

3. (b) Social Security Number

212-16-39534. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1897 8. (c) If alive, give age _____ years8. AGE: Years 48 Months 1 Days 4 It less than one day _____ hrs. _____ min.9. Birthplace Port Deposit, Cecil Co. Md.
(Town, county, and state)10. Usual occupation Painter11. Industry or business House12. Name Hugh F. Burlin13. Birthplace Cecil Co. Md.14. Maiden name Hanley E. Burlin15. Birthplace Cecil Co. Md.16. Informant Leo BurlinAddress Port Deposit, Md. ST. D.17. burial Date thereof March 10, 1945

(Burial, cremation, or removal, With?) (month) (day) (year)

Cemetery or crematory Asbury AveLocation Port Deposit, Md. Rural18. Funeral director W. A. Patterson & SonAddress Levyville, Md.19. March 9, 1945 James E. Dougherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7- 1945 4:50 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1945 to March 6, 1945 and that I last saw him alive on March 6, 1945

Immediate cause of death _____

Due to Acute NephritisDue to Grippe

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. F. Johnson M.D.Address Port Deposit, Md. M. D. or other _____Date signed 3/9/45

CERTIFICATE OF DEATH

RECEIVED

APR 5 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

02793

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Elkton, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RD 4
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie Elizabeth Burns

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Andrew Burns

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1886 8. (c) If alive, give age years

8. AGE: Years 39 Months 1 Days 2 If less than one day hrs. min.

9. Birthplace Lawrenceville, Ga. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Fadelers
 13. Birthplace Sayford Co. Md.

MOTHER 14. Maiden name May Cruse
 15. Birthplace Sayford Co. Md.

16. Informant Andrew Burns
 Address Elkton, Md. R.F.D.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereon March 16, 1945
 (month) (day) (year)
 Cemetery or crematory Asbury
 Location Perryville, Md. Rural

18. Funeral director A. E. Patterson & Son
 Address Perryville, Md.

19. Mar 14 19 45 JR Frazier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 45 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1 19 44 to March 13 19 45
 and that I last saw him alive on March 13 19 45

Immediate cause of death

Cerebral hemorrhage

Due to arteriosclerosis

Due to of unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Frank J. Frazier M. D. or other

Address 202 Oak View Street Date signed 3-14-45
Elkton, Md.

CERTIFICATE OF DEATH

RECEIVED

MAR 16 1945

BUREAU 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-22)

CERTIFICATE OF DEATH

02794

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
..... hrs. min.9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)

Cemetery or crematorium.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1945, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 16, 1944, to March 25, 1945.

and that I last saw him alive on Feb 25, 1945.

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

RECEIVED

APR 5 1945

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02795

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CecilCity or town Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 W. Biddle Street

(If rural, give LOCATION)

2(a) If veteran, name war WW I ✓

3. (a) FULL NAME

WALTER CHEEKS

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Nina Marce6. (c) If alive, give age Unknown years7. Birth date of deceased (mo., day, yr.) December 25, 18948. AGE: Years 50 Months 7 Days 10 If less than one day

... hrs. ... min.

9. Birthplace Macon, N.C.

(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

12. Name Landine Cheeks13. Birthplace Unknown14. Maiden name Fannie (Unknown)15. Birthplace Unknown16. Informant Hospital RecordsAddress Veterans Administration, Perry Point, Md.17. Removal 3-8-45

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Mt. AUBURN CEMETERYLocation BALTIMORE, Md.18. Funeral director Mrs. Hensley, 578 W. Biddle St.Address Baltimore, Md.19. March 8, 1945 James F. Dougherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 45 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 7 19 44 to March 7 19 45and that I last saw him alive on March 7 19 45

Immediate cause of death

Syphilis of central nervous systemmeningo encephalitic type

DURATION

26 yrs.

Due to

Due to

Other conditions Psychosis with syphilis ofcentral nervous system, meningo-encephali-tic type (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE E. R. LINGER, Lt. Col., M.C. Clinician

Veterans Administration, Perry Point, Md.

Address

Date signed 3-7-45

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MAR 14 1945

BUREAU V. S.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02796

Reg. Diat. No. 94

1. PLACE OF DEATH:

County..... Cecil
 City or town..... North East
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Cecil
 City or town..... North East, Md
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....
(If rural, give LOCATION)
 2.(a) If veteran, name war..... not a veteran

3. (a) FULL NAME

Elizabeth Ann Craig

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... George W Craig
 7. Birth date of deceased (mo., day, yr.)..... Feb 3 1855 8. (c) If alive, give age..... years
 8. AGE: Years..... 90 Months..... 1 Days..... 17 If less than one day..... hrs. min.

9. Birthplace..... Cecil Co., Md
(Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... Evan P. Sentman
 13. Birthplace..... Penna
 14. Maiden name..... Lizzella Rutter
 15. Birthplace..... Md

16. Informant..... Mrs Pauline Reynolds
 Address..... North East, Md.

17. Burial Date thereof..... March 25 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Methodist
 Location..... North East, Md

18. Funeral director..... Joseph P. Shaw
 Address..... North East, Md

19. Mar 24 19 45 Lea Brerena
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 21 19 45 at..... M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19..... to Mar 21 19 45
 and that I last saw him alive on March 19 19 45
 Immediate cause of death.....
Chronic Valvular
Heart Disease
 Due to.....
 Due to.....
 Other conditions.....

DURATION

(Include pregnancy within 3 months of death)

Major findings of operation..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
(City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... W. Brein Cumberland
M. D. or other
 Address..... W. Brein Cumberland Date signed..... Mar 27 1945

CERTIFICATE OF DEATH

RECEIVED
APR 2 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

CERTIFICATE OF DEATH

02797

Reg. Dist. No. 95

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-25-45 to 1-27-45

and that I last saw him alive on 1-27-45

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

02798

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town ELKTON, Md. RD 3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 85 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Rural Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

EDWIN HENRY GALLAHER

3.(b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
 6.(b) Name of husband or wife Clara GALLAHER

6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) JAN. 23, 1960

8. AGE: Years 85 Months Days If less than one day
 hrs. min.

9. Birthplace ELKTON, Md. RD 3
 (Town, county, and state)

10. Usual occupation HARDWARE DEALER

11. Industry or business

FATHER 12. Name John EVANS GALLAHER
 13. Birthplace ELKTON, Md.

MOTHER 14. Maiden name ANNIE CHANDLER
 15. Birthplace Earleville, Md.

16. Informant Marcia Butler
 Address Elkton, Md. R.D. 3.

17. Burial Date thereof Mar 18 - 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cherry Hill Cemetery
 Location Cherry Hill Cecil Co Md

18. Funeral director Thomas E. Plummer
 Address Elkton R.D. 3 Md

19. Mar 16 19 45 JR Fraser
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 - 45 19 45 at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 30 to March 15 - 45 and that I last saw him alive on March 14 19 45

Immediate cause of death Chronic Endocarditis DURATION
 Due to Chronic Interstitial nephritis
 Due to
 Other conditions Senility
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

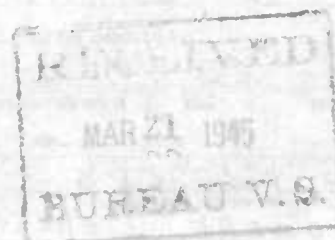
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hubert Bates, M.D. M. D. or other
 Address Elkton Md Date signed 3/16/45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02799

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH: CECIL
County.....
City or town..... PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 15 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution?..... Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Caroline
City or town..... Denton
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2(a) If veteran, name war..... "I"

3. (a) FULL NAME
GARY, William M.

3. (b) Social Security Number
-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife..... Mrs. Grace ? Gary
6. (c) If alive, give age..... Unknown years
7. Birth date of deceased (mo., day, yr.) July 21, 1894
8. AGE: Years 50 Months 8 Days 8 If less than one day
..... hrs. min.

9. Birthplace..... Denton, Md.
(Town, county, and state)
10. Usual occupation..... Farmer
11. Industry or business.....
12. Name..... William H. Garey
13. Birthplace..... Denton, Md.
14. Maiden name..... Georgie Roop
15. Birthplace..... Denton, Md.

16. Informant..... Hospital Records
Address..... Veterans Administration, Perry Point, Md.
17. Removal..... Date thereof..... March 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Denton Cemetery
Location..... Denton, Md.

18. Funeral director..... J. Virgil Moore
Address..... Denton, Md.

19. 3/29 1945 Jane F. Dougherty
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 29 1945 at 5:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 16 1945 to March 29 1945
and that I last saw him alive on March 29 1945

Immediate cause of death..... Chronic Myocarditis
DURATION Over 1 yr.

Due to..... Myocardial Degeneration Over 1 yr.
Pericardial Effusion Over 1 yr.
Due to..... Coronary Arteriosclerosis Over 1 yr.

Other conditions..... Psychosis with somatic disease Over 1 mo.
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results..... Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. B. Reecer
Clinical Director M. D. or other

Address..... Perry Point - Md. Date signed..... March 27, 1945

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

NOT TO BE USED FOR OTHER PURPOSES

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

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NAME OF CHILD

DATE OF BIRTH OF CHILD

RECEIVED
APR 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

CERTIFICATE OF DEATH

Reg. Dist. No. 02800 96

1. PLACE OF DEATH:

County Cecil
City or town Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: US Naval Hospital, NavTracenter, Bainbridge, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State VIRGINIA County Henrico
City or town RICHMOND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 East 41st Street
(If rural, give LOCATION)
WORLD WAR II
2.(a) If veteran, name war

3. (a) FULL NAME

Richard Herman GETLING

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced SINGLE
6.(b) Name of husband or wife Not married
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 28, 1926
8. AGE: Years 18 Months 7 Days 21 If less than one day hrs. min.

9. Birthplace Richmond, Henrico, Virginia
(Town, county, and state)
10. Usual occupation US Navy

11. Industry or business

FATHER 12. Name Ernest Lee GETLING
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown

16. Informant US NAVAL HOSPITAL, NAVTRACEN
BAINBRIDGE, MARYLAND.
Address

17. Removal Date thereof March 20-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory To Joseph W. Blakey Funeral Home
Richmond, Va.
Location

18. Funeral director W. A. Patterson & Son
Perryville, Md.
Address

19. March 20, 1945 James E. Daugherty
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 19 45 at 4:37 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 March 19 45 to 19 March 19 45
and that I last saw him alive on 19 March 1945

Immediate cause of death PNEUMONIA, lobar, Streptococcal

DURATION

24 hrs.

Due to

Due to

Other conditions Scarlet Fever 36 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Philip Myers Lt. (MC) USN
M. D. or other

Address Bainbridge, Md. Date signed 19 March 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Ebelton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Hotel East
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Newton Gibson

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife James D Gibson

7. Birth date of deceased (mo., day, yr.) Nov-10 1883 6. (c) If alive, give age 65 years

8. AGE: Years 61 Months 4 Days 18 If less than one day hrs. min.

9. Birthplace Bayridge Cecil Co. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James H. Lynch

13. Birthplace Md

14. Maiden name Rebecca Tyson

15. Birthplace Md

16. Informant James D Gibson

Address North East, Md -

17. (Burial, cremation, or removal. Which?) Date thereof Mar 31 1945
(month) (day) (year)

Cemetery or crematory St. Ebenezer

Location North East rural

18. Funeral director Joseph R. Gant

Address North East, Md

19. Mar 29 1945 J. R. Frager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1938 to March 28 1945 and that I last saw him alive on March 28 1945

Immediate cause of death Pneumo-pneumonia

DURATION

1 day

Due to Acute Bronchial Asthma 12 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. David W. Lecker, M.D.

Address Elkton, Md Date signed March 29

CERTIFICATE OF DEATH

RECEIVED
APR 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Entry and correction
of item 17 made on state-
ment of funeral director in person 3-12-45, L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

02802

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 15 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County -
City or town 218 S. Exeter Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore, Md.
(If rural, give LOCATION)
2(a) If veteran, name war W.W. I

3. (a) FULL NAME

GRIMALDI, Guiseppi

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Unknown
6. (c) If alive, give age Unknown years
7. Birth date of deceased (mo., day, yr.) August, 1899 (day unknown)
8. AGE: Years 55 Months 7 Days - If less than one day - hrs. - min.

9. Birthplace Rome, Italy
(Town, county, and state)
10. Usual occupation Tailor
11. Industry or business -
12. Name Dominick Grimaldi
13. Birthplace Unknown
14. Maiden name Rose Grimaldi (Maiden name unknown)
15. Birthplace Unknown

16. Informant Hospital Records
Address Veterans Administration, Perry Point, Md.
17. Removal 3-2-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory HOLY REDEEMER CEM.
Location BALTIMORE MD

18. Funeral director John J. Noca
Address Trinity & High Sts., Balto., Md.
19. March 2, 1945 James E. Dougherty
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945 at 4:00A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1944 to March 2, 1945
and that I last saw him alive on March 2, 1945

Immediate cause of death Cerebral Hemorrhage
DURATION 4 Da.
Due to Cerebral Arteriosclerosis Over 6 mo.
Due to -
Other conditions Psychosis with Cerebral Arteriosclerosis Over 6 mo.
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -
Autopsy results Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -

23. SIGNATURE A. J. Hollinger
24. HOLLINGER, Lt. Col., M.C. Civilian Control Director
Address Veterans Administration Date signed 3-2-45
Perry Point, Md.

RECEIVED

MAR 9 1945

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02803

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs., 8 mos., 25 days
Hospital, institution, or street address where death occurred:
Veterans Administration Facility
How long in hospital or institution? 19 yrs., 8 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Blair
City or town Ashville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #1
(If rural, give LOCATION)
2. (a) If veteran, name war World War I ✓

3. (a) FULL NAME

HANLIN, Cyril

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife --

7. Birth date of deceased (mo., day, yr.) November 19, 1895 6. (c) If alive, give age -- years

8. AGE: Years 49 Months 3 Days 18 If less than one day -- hrs. -- min.

9. Birthplace Ashville, Pa.
(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Mining

12. Name Unknown - deceased

13. Birthplace Unknown

14. Maiden name Unknown - deceased

15. Birthplace Unknown

16. Informant Records - Veterans Administration

Address Perry point, Md.

17. Removal 8-11-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Thomas Cemetery, Ashville, Pa.

Location Ashville, Pa.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. March 11, 1945 (Date rec'd by registrar) Dr. F. S. Sengler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1925 to March 9, 1945 and that I last saw him alive on March 9, 1945

Immediate cause of death Tuberculosis, pulmonary, chronic, far advanced, active DURATION over 7 mos

Due to --

Due to --

Other conditions Dementia Praecox, Hebephrenic type 20 yrs.
(Include pregnancy within 3 months of death)

Major findings at operations --

Date of op. --

Autopsy results Tuberculosis, pul., chr., F.A., active

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE A. E. Trollinger

A. E. TROLLINGER, Lt. Col. M.C., Chief Director

Address Vets. Adm. Perry Point, Md. Date signed 3-10-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

Reg. Dist. No. 92

02804

1. PLACE OF DEATH

County... EssexCity or town... Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Essex Jail, North St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... EssexCity or town... Essex
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Harris

3. (b) Social Security Number

218-18-8587

4. Sex

M.

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Jan. 18, 1900

8. AGE:

Years

Months

Days

If less than one day

45117

.....hrs.

.....min.

9. Birthplace

Essex, Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Trunk Explosives

12. Name

Charles C. Harris

13. Birthplace

Essex, Md.

14. Maiden name

Daisy Sanders

15. Birthplace

Newark, Del.

16. Informant

Charles Edward Harris

Address

Essex, Md.

17.

Burial

Date thereof

3/12/45
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Essex Colored Cem.

Location

Essex, Md.

18. Funeral director

H. W. Ripper

Address

Essex, Md.

19.

Mar 12 1945

(Date rec'd by registrar)

J. F. Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 8, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Acute Alcoholic

CAUSATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Dodson

Medical Examiner

Cecil County

M. D. or other

Address

W. H. DodsonDate signed 3-9-45

CERTIFICATE OF DEATH

RECEIVED
MAR 14 1945
SUP: 3

RECEIVED MAR 14 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

02805

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL
VETERANS ADMINISTRATION, Perry Point, Md.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 11 months

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town 1909 W. North Avenue, Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1909 W. North Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war Span. American

3. (a) FULL NAME

HARTMAN, Edward

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 45, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7, 19 40, to March 7 19 45and that I last saw him alive on 19Immediate cause of death Coronary Occlusion Less than 24 hrs.Due to Coronary Arteriosclerosis
with myocardial damage 5 yrs.

Due to

Other conditions Psychosis with arteriosclerosis, cerebral Less than 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Hollinger

TROLLINGER, Lt. Col., M.C. M. D. or other

Address Veterans Administration Date signed 3-8-45

Perry Point, Md.

3. (a) FULL NAME

HARTMAN, Edward

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 45, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7, 19 40, to March 7 19 45and that I last saw him alive on 19Immediate cause of death Coronary Occlusion Less than 24 hrs.Due to Coronary Arteriosclerosis
with myocardial damage 5 yrs.

Due to

Other conditions Psychosis with arteriosclerosis, cerebral Less than 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Hollinger

TROLLINGER, Lt. Col., M.C. M. D. or other

Address Veterans Administration Date signed 3-8-45

Perry Point, Md.

6. (b) Name of husband or wife Florence Whittier6. (c) If alive, give age Unknown years7. Birth date of deceased (mo., day, yr.) April 19, 18758. AGE: Years Months Days If less than one day
69 10 16 hrs. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

12. Name Henry M. Hartman13. Birthplace Germany14. Maiden name Elizabeth Eisenroad15. Birthplace Baltimore, Md.16. Informant Hospital RecordsAddress Veterans Administration, Perry Point, Md.17. Removal Date thereof 3-9-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.Funeral director Pennington & Son, Havre de Grace, Md.Address Havre de Grace, Md.19. March 9 19 45 Dr. W. E. Hollinger

(Date rec'd by registrar) Registrar

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Manner of death

6. Signature of physician

7. Signature of registrar

8. Signature of informant

9. Signature of witness

10. Signature of official

11. Signature of funeral director

12. Signature of undertaker

13. Signature of cemetery

14. Signature of burial

15. Signature of interment

16. Signature of record

17. Signature of certificate

18. Signature of death

19. Signature of burial

20. Signature of record

21. Signature of certificate

22. Signature of death

23. Signature of burial

24. Signature of record

25. Signature of certificate

26. Signature of death

27. Signature of burial

28. Signature of record

29. Signature of certificate

30. Signature of death

31. Signature of burial

32. Signature of record

33. Signature of certificate

34. Signature of death

35. Signature of burial

36. Signature of record

37. Signature of certificate

38. Signature of death

39. Signature of burial

40. Signature of record

41. Signature of certificate

42. Signature of death

43. Signature of burial

44. Signature of record

RECEIVED
APR 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-2)

02806

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Veterans Administration, Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Veterans Administration Facility, Perry PointHow long in hospital or institution? Same as above Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Not given in
Colmar Manor Postal Guide

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 4312 Monroe Street

(If rural, give LOCATION)

2(a) If veteran, name war World War 1

3. (a) FULL NAME

HILL, Harry

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Janette (Maiden name unknown)6. (c) If alive, give age Unknown years

7. Birth date of

deceased (mo., day, yr.)

June 3, 1888

8. AGE:

Years

56

Months

9

Days

3

If less than one day

hrs.min.

8. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

Interior Decorator

11. Industry or business

-

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point

17.

Removal

(Burial, cremation, or removal. Which?)

Date thereof

3-8-45 Md.

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Va.

18. Funeral director

Pennington & SonAddress Havre de Grace, Md.

19.

(Date rec'd by registrar)

March 8, 45 John E. Pennington

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 6 19 45 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 27 19 45 to March 6 19 45and that I last saw him alive on March 6 19 45

Immediate cause of death

Central Nervous System Les.Meningoencephalitic type Over 1 yr.

Due to

Due to

Other conditions

Psychosis with syphilisof Central Nervous System, Meningo-encephali-
tic Type (Include pregnancy within 3 months of death) About 3 mo.

Major findings of operations

Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John E. Pennington Director, Veterans Administration
Perry Point, Md. Date signed 3-7-45

RECEIVED
MAR 29 1945
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

Reg. Dist. No. 92

02807

1. PLACE OF DEATH: Cecil
 County Rural near Elkton, Md.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
 Elkton R.D. 4, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Md.
 State Cecil
 County Rural near Elkton, Md.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 Street No. Elkton R.D. 4
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Frank Hokuf

3. (b) Social Security Number

717-07-5661

4. Sex M. 5. Color or race wh 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Matilda Hokuf

7. Birth date of deceased (mo., day, yr.) May 9, 1885

8. AGE: Years 59 Months 10 Days 19 If less than one day hrs. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual occupation Watchman

11. Industry or business Penn. R.R.

12. Name James Hokuf

13. Birthplace Czechoslovakia

14. Maiden name Barbara Moravec

15. Birthplace Czechoslovakia

16. Informant Mrs. Matilda Hokuf

Address Elkton R.D. 4 Md.

17. Burial Date thereof Mar 31/45 (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director S.W. Pappin

Address Elkton, Md.

19. Mar 31 19 45 J.R. Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 28, 1945, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1944, to Mar. 28, 1945, and that I last saw him alive on March 23, 1945.

Immediate cause of death Adeno-Carcinoma present in the left axilla secondary to an undetermined primary site.

Due to primary site.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Adeno-Carcinoma Date of op. 1/11/45

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Arthur E. Sweeney, M.D.
 Address Elkton, Maryland Date signed 3/29/45

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-P)

CERTIFICATE OF DEATH

02808
Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perryville, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 mos.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED?

(For newborn infants give residence of mother)
 State Tennessee County Lawrence
 City or town Lawrenceburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rebecca Charlene Holt

3. (b) Social Security Number

4. Sex f. 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 14, 1943
 8. AGE: Years 1 Months 7 Days 14 It less than one day _____ hrs. _____ min.

9. Birthplace Lawrenceburg, Lawrence co, Tenn.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name Charles W. Holt

13. Birthplace Lawrence co, Tenn.

14. Maiden name Robert Nell Gibbs

15. Birthplace Lawrence co, Tenn.

16. Informant Charles W. Holt

Address Lawrenceburg, Tenn.

17. Removal & Burial Date thereof March 29, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Wimosa, Cem.

Location Lawrenceburg, Tenn.

18. Funeral director Lu & Patterson & Son

Address Perryville, Ind.

19. Mar 29 1945 Dune E. Doughty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1945, to March 28 1945, and that I last saw him alive on March 28 1945.

Immediate cause of death Pulmonary congestion DURATION 1 day

Due to Congenital hepatic hypertrophy hemolytic jaundice Birth

Other conditions Mongolian idiosy

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lu & Patterson & Son M. D. or other _____

Address Lawrenceburg, Tenn. Date signed March 29

DEPARTMENT OF JUSTICE

CENTRAL INTELLIGENCE AGENCY

RECEIVED

APR 5 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02809

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4514 - 32nd St.
(If rural, give LOCATION)
2.(a) If veteran, name war WW. I

3. (a) FULL NAME

CLARENCE W. JONES

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 2-15-1887 8. (c) If alive, give age - years

8. AGE: Years 58 Months - Days 20 If less than one day - hrs. - min.

9. Birthplace Indiana
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business -

FATHER 12. Name William H. Jones 13. Birthplace Unknown

MOTHER 14. Maiden name Lula Ashley 15. Birthplace Unknown

16. Informant Hospital Records
Address Veterans Administration, Perry Point, Md.

17. Removal 3-9-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National Cemetery
Location Arlington, Va.

18. Funeral director Pennington & Son, Havre de grace, Md.
Address -

19. March 9 19 45 Irvin E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 45 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 19 45 to March 7 19 45 and that I last saw him alive on March 7 19 45

Immediate cause of death Thrombosis, cerebral, left DURATION 7 mo.

Due to Disease of Myocardium, Myocarditis Unknown

Due to Arteriosclerosis, general & cerebral Unknown

Other conditions Psychosis, with arteriosclerosis, general & Cerebral
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Irvin E. Daugherty
E. TROLLINGER, Lt. Col. M.C., M. D. or other
Clinical Director
Address Veterans Administration, Perry Point, Md. Date signed March 8, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RECEIVED
APR 5 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

02810

Reg. Diat. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elk Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town Elk Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie Sarah Kay

3. (b) Social Security Number

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

Female White Widow6.(b) Name of husband or wife Robert John Kay

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July, 6, 1874

8. AGE: Years _____ Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Cecil County
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Francis Atkinson13. Birthplace Cecil County14. Maiden name Mary Catherine Dennison15. Birthplace Cecil County16. Informant Mary Kay CookeAddress Elk Mills17. Burial Date thereof 3-7-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cherry HillLocation Cherry Hill, Md.18. Funeral director Thomas E. BlumathyAddress Elkton R. H. 5 - Ind19. Mar 5 19 45 JR Frazier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 45 at 1:15 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 45 to March 4 19 45 and that I last saw her alive on March 4 19 45Immediate cause of death _____ DURATION _____
Pulmonary edema 2 hours
Chronic endocarditis unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. H. M. Frazier M. D. or other _____Address Elkton - Md Date signed 2/5/45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 9 1945

BUREAU

PLEASE WRITE PLAINLY, WITH ~~PRE~~ WRITING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02811

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 221 E High St
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

Georgianna Knight

3. (b) Social Security Number

none

4. Sex ♀ 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Edwin S Knight

7. Birth date of deceased (mo., day, yr.) Oct 7 1871 6. (c) If alive, give age — years

8. AGE: Years 73 Months 5 Days 24 If less than one day — hrs. — min.

9. Birthplace Elkton, Md. Rural
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ✓

FATHER 12. Name Elmer Stearns
 13. Birthplace West Penna

MOTHER 14. Maiden name Mary J Perry
 15. Birthplace Md

16. Informant John E Knight
 Address 221 E High St Elkton, Md

17. Burial Date thereof Apr 3 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Method Cemetery
 Location Cherry Hill Md

18. Funeral director Joseph R Bryant
 Address North East, Md

19. Cecil 19 45 J H Frazer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 45 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18 19 44 to March 31 19 45
 and that I last saw her alive on March 31 19 45

Immediate cause of death Myocardial infarction

DURATION

3 mo.

Due to Coronary Regurgitation

Other conditions Atrophy of muscles
 (Include pregnancy within 3 months of death)

Major findings of operations none Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L Johnson M.D.
Elkton, Md. Date signed 4/2/45

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

EDUCATION

DATE OF BIRTH

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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DATE OF DEATH

RECEIVED

APR 13 1915

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02812

Reg. Diat. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

William W. Lewis

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Florence M. Lewis
6. (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) Jan. 25, 1856
8. AGE: Years 89 Months 1 Days 12 If less than one day _____ hrs. _____ min.
9. Birthplace Charlestown Cecil Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James W. Lewis
13. Birthplace Cecil Co. Md
14. Maiden name Eveline Grant
15. Birthplace Cecil Co. Md
16. Informant Florence M. Lewis
Address Charlestown, Md
17. Burial Date thereof March 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
Cemetery or crematory Charlestown
Location Charlestown, Md
18. Funeral director W. A. Patterson & Son
Address Perryville, Md.
19. March 12, 1945 J. E. Doughty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1945, to March 9 1945
and that I last saw him alive on March 9 1945
Immediate cause of death General Atheroma
DURATION 10 yrs
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE J. F. Magraw
Address Perryville Md M. D. or other _____
Date signed 3/12/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

FILM No. G 94 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

02813

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr. 7 mo. 9 Da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ILLINOIS

County Cook

City or town Chicago
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1947 Schiller Street
(If rural, give LOCATION)

2. (a) If veteran, name war WW I ✓

3. (a) FULL NAME

MANDRAVITZKY, Justin G.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 19, 1891

8. AGE:

53

Years

54

Months

11

Days

21

If less than one day

hrs.

min.

9. Birthplace

Lithuania

(Town, county, and state)

10. Usual occupation

Tailor

11. Industry or business

FATHER

12. Name Adam Mandravitzky

13. Birthplace

Poland

MOTHER

14. Maiden name Hannah Danidaitis

15. Birthplace

Poland

16. Informant

Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal

Date thereof 3-13-45

(Burial, cremation, or removal. Which?) FULLY NATIONAL (month) (day) (year)

Cemetery or crematory

Bolt Redemptor Cemetery

Location Belair Road, Baltimore, Md.

18. Funeral director

John J. Cowan & Son

Address

Baltimore, Md.

19.

(Date rec'd by registrar)

March 13 19 45 John E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 45 at 9:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31 19 41 to March 12 19 45

and that I last saw him alive on March 12 19 45

Immediate cause of death

Cerebral hemorrhage

DURATION

2 Da.

Due to Cerebral Arteriosclerosis

Over 1 yr.

Due to

Other conditions Psychosis, Post Traumatic

Mental Enfeeblement

Over 3 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Not performed Date of op. -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE

John E. Daugherty M. D. or other

Address Perry Point, Md. Date signed 3/13/45

RECEIVED
MAR 23 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

CERTIFICATE OF DEATH

02814

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Veterans Administration, Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo., 21 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. None

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War.

3. (a) FULL NAME

ALBERT B. MC KINLEY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Unknown6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) November 1, 1876

8. AGE:

Years 68Months 4Days 12

It less than one day

- hrs.- min.

9. Birthplace

Hancock, Md.

(Town, county, and state)

10. Usual occupation

Store Owner (Retired)

11. Industry or business

-

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point, Md.

17.

Removal
(Burial, cremation, or removal. Which?)

Date thereof

3-13-45

(month) (day) (year)

Cemetery or crematory

Hancock Cemetery

Location

Hancock, Maryland

18. Funeral director

Address

Pennington & Son, Havre de Grace, Md.

19.

March 13, 1945
(Date rec'd by registrar)

19. 45

James E. Hargrave

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 45 at 12:15P M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 19 44 to March 13 19 45and that I last saw him alive on March 13 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

5 da.Due to Arteriosclerosis, cerebral Over 2 yr.

Due to

Other conditions Psychosis with Cerebral
Arteriosclerosis Over 6 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury -Injured at work? -23. SIGNATURE J. E. Hargrave
PHYSICIAN, Lt. Col., M.C., Clinical DirectorAddress Veterans Administration, Perry Point, Md. Date signed 3-13-45

RECEIVED

APR 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

02815

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Facility
 How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Dist. of Columbia County --
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 515 Sixth St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I ✓

3. (a) FULL NAME

OKSON, Sam

3. (b) Social Security Number

unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Unknown - deceased

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1892

8. AGE:

Years

Months

Days

If less than one day

52

10

27

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

--

FATHER

12. Name

Unknown

13. Birthplace

--

MOTHER

14. Maiden name

Unknown

15. Birthplace

--

16. Informant

Records - Veterans Administration,

Address

Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 3-13-45

(month) (day) (year)

Cemetery or crematory

Baltimore National

Location

Baltimore, Md.

19. Funeral director

PENNINGTON & SON

Address

Havre de Grace, Md.

19. March 13, 1945
 (Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 45, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 19 45 to March 10 19 45, and that I last saw him alive on March 10 19 45

Immediate cause of death

Tumor of the Ileum, nature unspecified

DURATION

Unknown

Due to

Due to

Other conditions

Psychosis, Involutional, paranoid
 (Include pregnancy within 8 months of death)

1 mo.

Major findings of operations

Date of op. ---

Autopsy results

Tumor of the Ileum, nature unspecified

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of ---

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) ---

Means of injury

Injured at work? ---

23. SIGNATURE

A. E. TROLLINGER, Lt. Col., M.D., Sec'y. DIR.
VETS. ADM. PERRY POINT, MD.
 Date signed 3-10-45

RECEIVED TO THE BUREAU OF THE ARMY

RECEIVED TO THE BUREAU OF THE ARMY

RECEIVED

APR 5 1945

BUREAU OF THE ARMY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14-2

CERTIFICATE OF DEATH

02816

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 min

Hospital, institution, or street address where death occurred:

262 Hollingsworth Manor.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CecilCity or town Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 262 Hollingsworth Manor.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Janie Peterson

3. (b) Social Security Number

None

4. Sex

F.

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 19, 1945

8. AGE:

Years

Months

Days

If less than one day

hrs. 10 min.

9. Birthplace

Elkton, Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name Roscoe J. Peterson13. Birthplace North Carolina14. Maiden name Thelma Honeycutt15. Birthplace North Carolina16. Informant Roscoe PetersonAddress 262 Hollingsworth Manor Elkton, Md.17. Burial Date thereof Mar 20/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ElktonLocation Elkton, Md.18. Funeral director H. W. PippinAddress Elkton, Md.19. Mar 20 19 45 JR Fraser

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 45, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 19 45, to March 19 19 45and that I last saw him alive on March 19 19 45

Immediate cause of death

Asphyxiation

DURATION

10 min

Due to

not known

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James L. Johns, M.D.

M. D. or other

Address Elkton, Md. Date signed 3/20/45

31-82

STAMP TO CENTRAL MAIL STATION

MAILED TO STAGHOUT

RECEIVED
MAR 23 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

02817

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil

City or town North East
(If outside city or town limits, write RURAL and give nearest town)

How long to above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Effie I Ruine

3. (b) Social Security Number

None

4. Sex

Female

5. Color of hair

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

John C Ruine

7. Birth date of deceased (mo., day, yr.)

Dec 27 1881

6.(c) If alive, give age 70 years

8. AGE:

63

Years

2

Months

9

Days

If less than one day

hrs.

min.

9. Birthplace

York Co. Pa.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

45

Lida V. Owens

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 - 1945 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to March 8 - 1945

and that I last saw him alive on March 5 - 1945

Immediate cause of death

acute cardiac dilatation

DURATION

Due to

chronic myocarditis

Due to

hypertension

Other conditions

arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Owens

Address

MAR 10 1945

Date signed

CERTIFICATE OF DEATH

RECEIVED
APR 2 1945
BUREAU 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02818

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH: Cecil
County Rising Sun
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland Cecil
State County
City or town Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, same war

3. (a) FULL NAME Louise Marie Richards
3. (b) Social Security Number

4. Sex Female
5. Color or race white
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1948

8. AGE: Years 0 Months 0 Days 9 If less than one day hrs. min.

9. Birthplace Rising Sun Maryland
(Town, county, and state)
Infant

10. Usual occupation

11. Industry or business

12. Name Emerson Joseph Richards

13. Birthplace Baltimore Maryland

14. Maiden name Dorothy E. Slicker

15. Birthplace Perryville, Md.

16. Informant Dorothy Richards

Address Calora, Ind.

17. Burial, cremation, or removal, Which? Burial Date thereof Mar 13 1948
(month) (day) (year)

Cemetery or crematory West Nottingham

Location Calora Ind.

18. Funeral director J. E. Taysen

Address Rising Sun Ind.

19. Date rec'd by registrar Mch 13 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1948 to March 12 1948

and that I last saw her alive on March 11 1948

Immediate cause of death Hemorrhage from renal and gastrointestinal hemorrhage

Due to Congenital defective infant Here lip

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. Robinson M.D.

Address Oxford Penna Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permit 3-13-48

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

RACE

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

RECEIVED
APR 4 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02819

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mos.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Perryville, Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Franktown
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clifford W. Smeltzer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mabel A.

7. Birth data of deceased (mo., day, yr.)

Nov. 10, 1875

8. (c) If alive, give age

70 years

8. AGE:

Years

Months

Days

If less than one day

6943

hrs.

min.

6. Birthplace

Perryville, Cecil, Md.
(Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

Port of Foundry

FATHER

MOTHER

12. Name

Louis J. Smeltzer

13. Birthplace

Cecil Co. Md.

14. Maiden name

Mary Elizabeth Donahoe

15. Birthplace

Perryville, Cecil Co. Md.

16. Informant

Mrs. William Jack

Address

Port Deposit, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

March 16, 1945
(month) (day) (year)

Cemetery or crematory

St. Marks

Location

Perryville, Md. Rural

16. Funeral director

Ed A. Patterson & Son

Address

Perryville, Md.19. March 16, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. - 25, 1944 to March 11, 1945
 and that I last saw him alive on March 11, 1945.

Immediate cause of death

Carcinoma of Intestines & Liver

DURATION

1 yr.

Due to

Primary carcinoma of liverDuration: One year 1944-1945

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma ofLiver & Intestines Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

B. J. Brown M.D.

Address

Port Deposit

M. D. or other

Data signed 3/14/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 734

CERTIFICATE OF DEATH

02820

Reg. Dist. No. 91

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Capt. William Thomas Savin

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M. W. Married.

6. (b) Name of husband or wife Linda Savin

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) March 23, 1861

8. AGE: Years 83 Months 11 Days 28 It less than one day hrs. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)

10. Usual occupation Retd. Leg Capt.

11. Industry or business

12. Name Benedict Savin

13. Birthplace Queens Anne's Co. Md.

14. Maiden name Rebecka Knight

15. Birthplace Maryland

16. Informant Mrs. Linda Savin

Address Chesapeake City, Md.

17. Burial Date thereof Mar 23, 1945

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Bethel Rev Chesapeake City

Location Near Chesapeake City Md

18. Funeral director H. W. Pappan

Address Elkton, Md

19. March 23, 1945 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to March 20, 1945

and that I last saw him alive on March 19, 1945

Immediate cause of death acute myocardial infarction

Duo to Chronic myocarditis

Due to old age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. P. Davis M.D.

Address Chesapeake City, Md

Date signed 3/23/45

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

APR 4 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-2

CERTIFICATE OF DEATH

02821
96
Reg. Dist. No.

1. PLACE OF DEATH:

County CECIL
 City or town VETERANS ADMINISTRATION, Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yr. 19 da. 9 mo.
 Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County -
 City or town Baltimore, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1328 Dellwood Avenue, B
 (If rural, give LOCATION)
 2. (a) If veteran, name war P.I. ✓

3. (a) FULL NAME

STEIGERWALD, John T.

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) August 18, 1879
 6. (c) If alive, give age - years

8. AGE: Years 65 Months 7 Days - If less than one day - hrs. - min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation None11. Industry or business -

FATHER 12. Name Charles Steigerwald
 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Caroline (Unknown)
 15. Birthplace Unknown

16. Informant Hospital Records
 Address Veterans Administration, Perry Point, Md.

17. Removal Removal Date thereof 3-20-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Maryland

18. Funeral director Havre de Grace, Md.
 Address Havre de Grace, Md.

19. March 21 19 45 John E. Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 45 at 9:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 19 38, to March 18 19 45

and that I last saw him - alive on - 19 -

Immediate cause of death Cerebral Hemorrhage DURATION 5 da.

Due to Cerebral arteriosclerosis over 7 yrs.

Due to Aneurysm of aorta over 5 yrs.

Other conditions Psychosis with cerebral arteriosclerosis over 7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE J. E. Dougherty
John E. Dougherty, Lt. Col., M.C.,
Clinical Director
 Address Veterans Administration, Perry Point, Md. M. D. or other -
 Date signed 3/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 1 1945
BUREAU A & B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

02822

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... Cecil
 City or town... Ferryville Rural, Aikin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 5 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Cecil
 City or town... Ferryville Rural Aikin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Martha Agnes Thomas

3. (b) Social Security Number

4. Sex... Female 5. Color or race... white 6. (a) Single, married, widowed, or divorced... Married

6. (b) Name of husband or wife... William B. Thomas

7. Birth date of deceased (mo., day, yr.)... Sept. 2, 1878 6. (c) If alive, give age... 66 years

8. AGE: Years... 66 Months... 6 Days... 8 If less than one day... hrs. ... min.

9. Birthplace... Ferryville, Cecil co. Md.
 (Town, county, and state)

10. Usual occupation... House wife

11. Industry or business

12. Name... John Founds

13. Birthplace... Cecil co. Md.

14. Maiden name... Hannah E. Murphy

15. Birthplace... Cecil co. Md.

16. Informant... W. B. Thomas

Address... Ferryville, Md.

17. Burial... Burial Date thereat... March 14, 1945
 (Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory... Robury

Location... Longwood Rd. Rural

18. Funeral director... Lee A. Patterson & Son

Address... Ferryville, Md.

19. March 12, 1945 Jane E. Daugherty
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 10th 1945 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st 1845 to March 10, 1945 and that I last saw him alive on March 10, 1945

Immediate cause of death... Carcinoma of sigmoid DURATION 2 yrs

Due to.....

Due to.....

Due to.....

Other conditions... Chronic Cardiac

Renal Disease 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE... J. F. Magraw M. D. coroner

Address... Ferryville Md. Date signed... 3/12/45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED

RECEIVED

APR 5 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County BecilCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.Hospital, institution, or street address where death occurred:
Elkton med. HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ElktonCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. 503 Bow St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

J. Wesley Vernon

3. (b) Social Security Number

222-07-57614. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Emma Vernon6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Oct 28, 18668. AGE: Years 78 Months 4 Days 17 If less than one day hrs. min.9. Birthplace Delaware
(Town, county, and state)10. Usual occupation Retired11. Industry or business at home12. Name George W. Vernon13. Birthplace Berlin14. Maiden name Mary Hutton15. Birthplace New Jersey16. Informant Willard VernonAddress 503 Bow St. Elkton Md.17. Buried Date thereof 3/21/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Unionville CemeteryLocation Unionville, Del.18. Funeral director Albert J. McGrawAddress 2700 Wash. St. Wilmington, Del.19. Mar 17, 1945 Registrar J. H. Frazer
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945 at 7:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4, 1944 to Mar. 17, 1945and that I last saw him alive on March 17, 1945Immediate cause of death Cardiac Failure DURATIONDue to Carcinoma of the Prostate

Due to

Other conditions

(Incidental pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. C. E. ... M. D. or otherAddress Elkton, Md. Date signed 3/17/45

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MAR 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 02824 96

1. PLACE OF DEATH:

County Cecil
 City or town Bainbridge, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 6 months
 Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCenter, Bainbridge, Maryland
 How long in hospital or institution? 2 1/2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Dist. Columbia County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1317 - 22nd Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WORLD WAR II ✓

3. (a) FULL NAME

Joseph Edward WASHINGTON

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Frances Irvie Washington
 6.(c) If alive, give age 28 years
 7. Birth date of deceased (mo., day, yr.) 12/18/12
 8. AGE: Years 32 Months 2 Days 22 If less than one dayhrs.min.

9. Birthplace Fredericksburg, Virginia
 (Town, county, and state)
 10. Usual occupation U.S. Navy
 11. Industry or business

FATHER 12. Name William Horace WASHINGTON
 13. Birthplace King George County, Virginia
 MOTHER 14. Maiden name Eriana COLE
 15. Birthplace Virginia

16. Informant US Naval Hospital, NavTraCenter
 Address Bainbridge, Maryland

17. Removal 3 - 12-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory To, Brown & Brother Undertakers
 Location Fredericksburg, Virginia

18. Funeral director Ed a. Cattman & Son
 Address Curryville, Md.

19. Dec 12 1945 Irma E. Langhartz
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 March, 1945 19..... at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Nov 1944, to 10 March 1945

and that I last saw him in alive on 10 March, 1945
 Immediate cause of death TUBERCULOSIS, PULMON-ARY, CHRONIC, ACTIVE, FAR ADVANCED. DURATION 10 Month

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results confirmed above diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry C. Oard M. D. or otherAddress U.S.N.H. Bainbridge, Md. Date signed Mar 10, 1945

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APR 5 1945

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16445

CERTIFICATE OF DEATH

02825

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town PERRY POINT, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 3 mo. 9 da.
 Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 105 Washington St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war W.W.I

3. (a) FULL NAME

WILSON, James H. Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Jeanne Robert
 6. (c) If alive, give age Unknown years
 7. Birth date of deceased (mo., day, yr.) April 4, 1883
 8. AGE: Years 61 Months 11 Days 3 It less than one day
 hrs. min.

9. Birthplace Cumberland, Md.
 (Town, county, and state)
 10. Usual occupation Physician
 11. Industry or business -

12. Name Jacob Jones Wilson
 13. Birthplace Maryland
 14. Maiden name Marie Josephine McCormick
 15. Birthplace Maryland
 16. Informant Hospital Records
 Address Veterans Hospital, Perry Point, Md.
 17. Removal 3-8-45 Date thereof (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery Cumberland Cemetery
 Location Cumberland, Md.
 18. Funeral director Pennington & Son, Havre de Grace, Md.
 Address

19. March 8 1945 Issued by James F. Pennington Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

Midnight

20. DATE OF DEATH March 5 1945 at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1943 to March 5 1945
 and that I last saw him alive on March 5 1945

Immediate cause of death Strangulation by hanging DURATION

Due to

Due to

Other conditions Psychosis Manic Depressive, depressed type Over Eight years
 (Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results Not performed
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Suicide Date of 3-5-45
 Where did injury occur? V.A. Facility, Perry Point, Cecil Co.
 (City or town) (County) (State) Md.

Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -

Medical Examiner Philip Dodson Cecil County
 23. SIGNATURE Philip Dodson M. D. or other
 Address Perry Point, Md. Date signed 3-7-45

MANHATTAN DEPARTMENT OF HEALTH

111 W. Broadway, New York 1

CERTIFICATE OF DEATH

MANHATTAN DEPARTMENT OF HEALTH

NEW YORK CITY

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MAR 29 1945
BUREAU A B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

02826

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH: Cecil
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3-11-15 hr.
Hospital, institution, or street address where death occurred:
389 W. Main St.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md County Cecil
City or town..... Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 389 W. Main St.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME Henry Leroy Yedinak
3. (b) Social Security Number.....

4. Sex M. 5. Color or race wh. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Mar. 25, 1941

8. AGE: Years 3 Months 11 Days 15 It less than one day
.....hrs.min.

9. Birthplace Elkton, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business.....

12. Name Henry L. Yedinak

13. Birthplace Elkton, Md

14. Maternal name Katharine Deman

15. Birthplace Elkton, Md

16. Informant Henry L. Yedinak

Address Elkton, Md

17. Burial Date thereof 3/13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Catholic Cemetery

Location Chesapeake City, Md

18. Funeral director H. W. Pippin

Address Elkton, Md

19. Mar 12 1945 J. R. Trager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to March 10 1945 and that I last saw him alive on March 10 1945

Immediate cause of death Edema of Lungs

DURATION 1 hour

Due to Broncho Pneumonia

1 day

Due to Acute Bronchitis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation.....

.....Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert Bates, M.D.

Address Elkton Md Date signed 3/10/45

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 14 1985
BUREAU V.S.